Hawaii Insurance Division
Continuing Education Program
Provider Approval Application

Provider Number *(Leave Blank)*:

PLEASE PRINT CLEARLY OR TYPE
INCOMPLETE APPLICATIONS WILL BE REJECTED.
SUBMIT ONE ORIGINAL SIGNED APPLICATION AND TWO COPIES OF THE APPLICATION AND CORRESPONDING INFORMATION.

Provider Name:			FEIN Number:
CE Name:			
Names and Titles of Owners or Officers (list below - use addition sheet if necessary):			
Name / Title	Street Address, City, State, ZIP Code, Phone Number		Designations and Licenses
Physical Street Address (where records will be maintained)	City	State	ZIP Code
Business Mailing Address (if different than physical address):	City	State	ZIP Code
Business Voice Phone (with Ext. #, if applicable):	Business Toll-Free Phone (with Ext. #, if applicable):	Bus. Fax #:	
Business E-mail Address:	How long has this provider been in business?		

Has this provider or any of its owners, officers, or provider directors, been convicted of a felony involving moral turpitude, or had an insurance, financial-services, or educational license suspended or revoked? If yes, please explain in detail on a separate sheet. ☐ Yes ☐ No

Has this provider or any of its owners, officers, or provider directors, been convicted of a misdemeanor violating any law regulating insurance, or a public offense having as one of its necessary elements a fraudulent act or an act of dishonesty in the acceptance, custody, or payment of money or property? If yes, please explain in detail on a separate sheet. ☐ Yes ☐ No

How will this provider record attendance, report credit hours, and maintain records?

Are you approved as a CE Provider in any other state(s)? ☐ Yes ☐ No Are the courses open to the public? ☐ Yes ☐ No
If yes, which state(s)?

Type of Organization (check one): ☐ Professional Organization ☐ Training Company ☐ Insurance Company ☐ College/University ☐ Insurance Agency/Brokerage/Wholesaler ☐ Other _____

Has this provider operated under any other name? ☐ Yes ☐ No
If yes, please provide the name and address of each business under which this provider has operated (see instructions for details, use separate sheet if needed).

Name	Address

Will this provider have an internet web site that lists the dates, times, and locations of courses approved for insurance continuing education credit?
☐ Yes ☐ No If yes, please provide the web site address: _____

I certify that I have read the Hawaii Revised Statutes and agree to abide by those laws and the Hawaii insurance rules and regulations, the Americans with Disabilities Act, and all applicable state and federal equal employment opportunity and safety requirements. Additionally, I will require any instructors I utilize to teach courses to certify that they satisfy the requirements to be an instructor and to abide by those laws and rules applicable to instructors. I am aware that any failure to abide by the Hawaii Revised Statutes and rules may result in the termination of this provider's authorization to offer courses and that all course approvals will be simultaneously withdrawn.

_____ Applicant's Signature

_____ Date

_____ Print or Type Applicant's Name

_____ Title

OFFICE USE ONLY: *(Do Not write in this area)*

Effective Date: _____

Expiration Date: _____

|98 $_____

|51 $_____

|18 $_____

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THE FOLLOWING SECTION SHOULD BE COMPLETED BY THE PRIMARY CONTACT PERSON OF THE PROVIDER.
(List additional contact person(s), addresses, phone numbers, and e-mail on a separate sheet)

Contact Person of Provider:			
First Name	Middle Initial	Last Name	
Physical Street Address of Contact Person:	City	State	ZIP Code
Business Mailing Address of Contact Person (if different than physical address):	City	State	ZIP Code
Business Voice Phone (with Ext. #, if applicable):	Business Toll-Free Phone (with Ext. #, if applicable):	Bus. Fax #:	
E-mail Address:			

Contact Person Signature _____ Date _____

Print or Type Name of Contact Person _____ Title _____

It is imperative that providers notify the Hawaii Insurance Division in writing to update any changes to information submitted on this application.